# Texas HIV Case Management Standards of Care

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TEXAS
Department of State Health Services

A Healthy Texas

# Timeline

Below is our planned timeline for implementation. This may change based on input received.

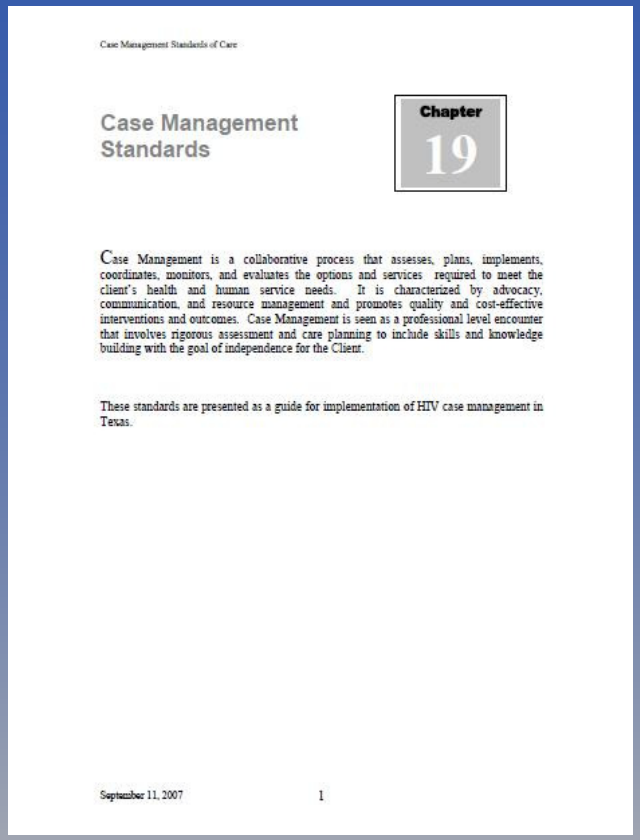
- June 14 – standards sent to All Parts participants
- June 20 – present changes at All Parts meeting
- June 21 – standards sent to expert panel for comment and feedback
- July 1 – standards posted on DSHS website for public comment
- July/August – town hall meetings held live and on-line to present overview of changes
- August 12 – revised draft released for review
- September 1 – Revised standards fully implemented

# Background

- 2007-2009: Texas HIV Case Management Project implemented
  - Literature review, Jurisdictional survey, Survey of Texas Part B sites
  - 2009 – Expert Panel convened, report released with their recommendations
  - December 2009 – DSHS released a report representing our vision for CM in Texas
- 2010 – 2011: Moving forward with recommendations
  - Contracted with UT to develop MCM Competency training course and road map
  - Established internal workgroup to revise Texas HIV CM Standards of Care

# Overview of Changes

The overall formatting of the standards has changed with an emphasis on making them more comprehensive, cohesive and to provide more guidance and direction for case management programs. We've borrowed from other successful state programs, including Wisconsin and New York.



Case Management Standards of Care

Case Management Standards

Chapter 19

Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes. Case Management is seen as a professional level encounter that involves rigorous assessment and care planning to include skills and knowledge building with the goal of independence for the Client.

These standards are presented as a guide for implementation of HIV case management in Texas.

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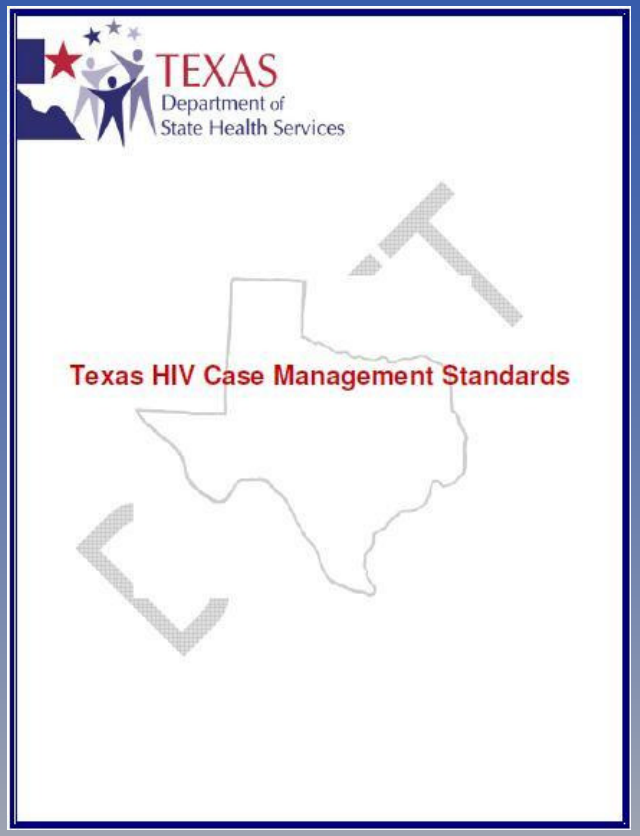
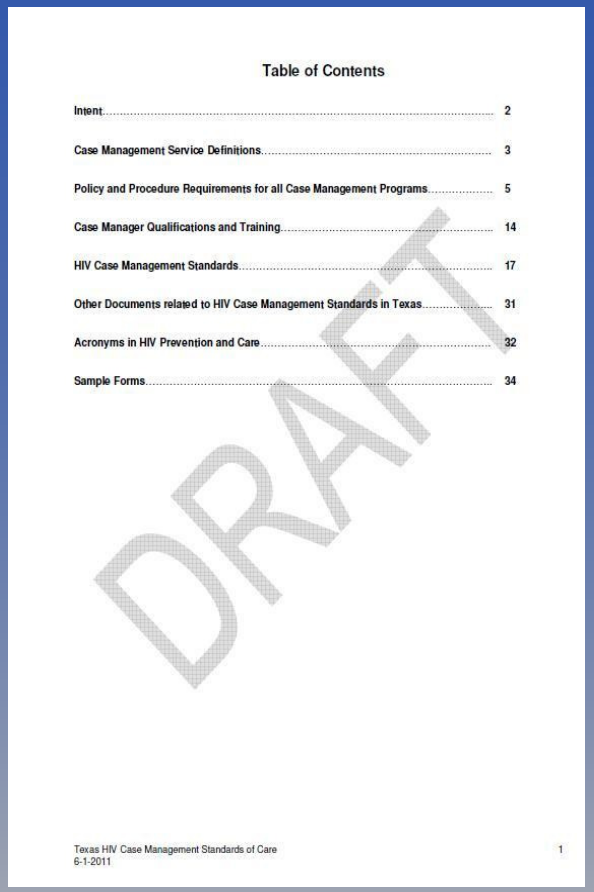


# Overview of Changes

The standards have now been divided into the following sections



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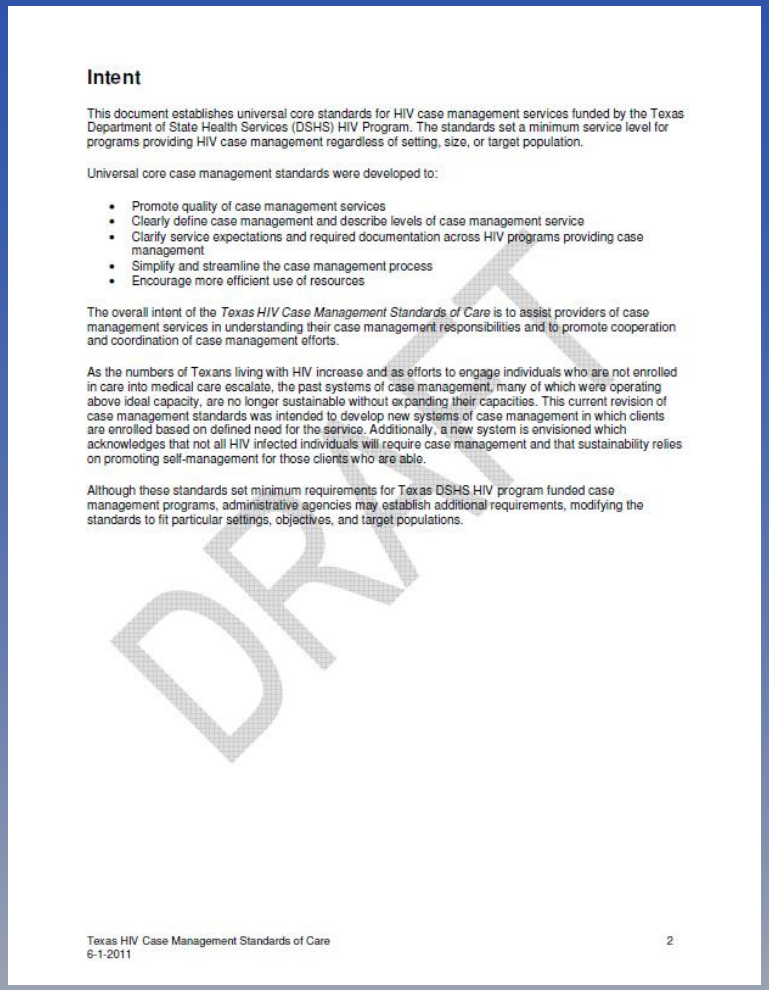
- CM Service Definitions
- P&P Requirements
- CM Qualifications and Training
- HIV CM Standards
- Other relevant documents
- Common acronyms
- Sample forms

# Overview of Changes
# Intent – page 2



**Intent**

This document establishes universal core standards for HIV case management services funded by the Texas Department of State Health Services (DSHS) HIV Program. The standards set a minimum service level for programs providing HIV case management regardless of setting, size, or target population.

Universal core case management standards were developed to:

- Promote quality of case management services
- Clearly define case management and describe levels of case management service
- Clarify service expectations and required documentation across HIV programs providing case management
- Simplify and streamline the case management process
- Encourage more efficient use of resources

The overall intent of the *Texas HIV Case Management Standards of Care* is to assist providers of case management services in understanding their case management responsibilities and to promote cooperation and coordination of case management efforts.

As the numbers of Texans living with HIV increase and as efforts to engage individuals who are not enrolled in care into medical care escalate, the past systems of case management, many of which were operating above ideal capacity, are no longer sustainable without expanding their capacities. This current revision of case management standards was intended to develop new systems of case management in which clients are enrolled based on defined need for the service. Additionally, a new system is envisioned which acknowledges that not all HIV infected individuals will require case management and that sustainability relies on promoting self-management for those clients who are able.

Although these standards set minimum requirements for Texas DSHS HIV program funded case management programs, administrative agencies may establish additional requirements, modifying the standards to fit particular settings, objectives, and target populations.

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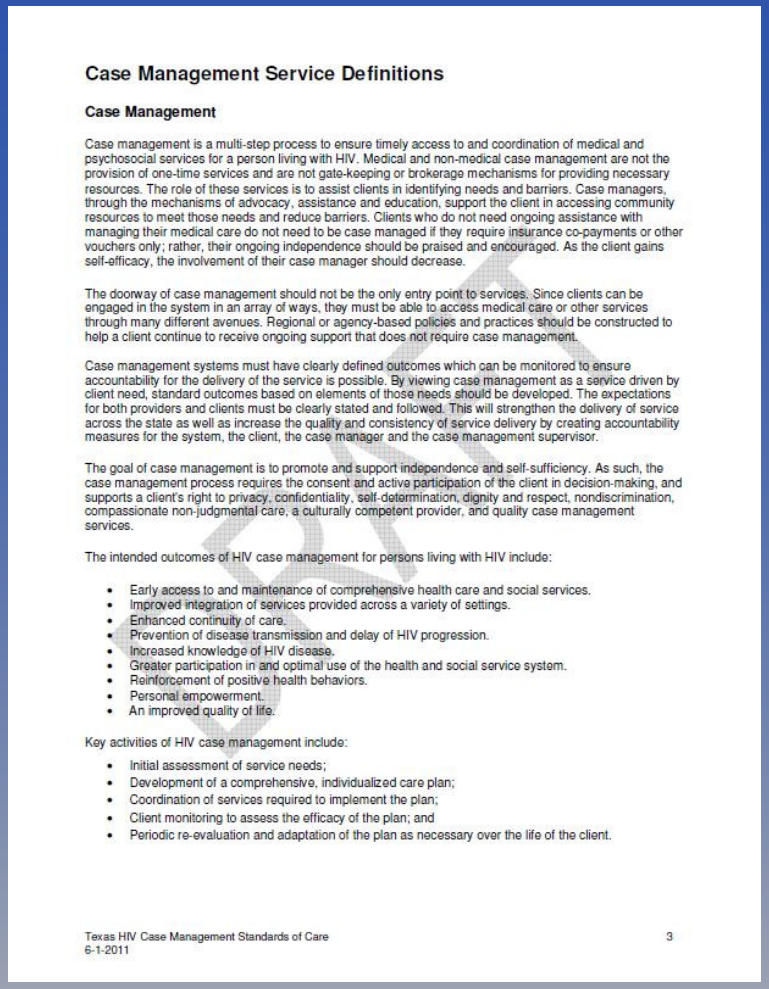
- Provide overall philosophy on how we view case management
- Language came from Expert Panel report and the DSHS report on the MCM Project
- Emphasizes enrolling clients in case management services based on need
- Promotes helping clients work towards self-management

# Overview of Changes
# Service Definitions - page 3



**Case Management Service Definitions**

**Case Management**

Case management is a multi-step process to ensure timely access to and coordination of medical and psychosocial services for a person living with HIV. Medical and non-medical case management are not the provision of one-time services and are not gate-keeping or brokerage mechanisms for providing necessary resources. The role of these services is to assist clients in identifying needs and barriers. Case managers, through the mechanisms of advocacy, assistance and education, support the client in accessing community resources to meet those needs and reduce barriers. Clients who do not need ongoing assistance with managing their medical care do not need to be case managed if they require insurance co-payments or other vouchers only; rather, their ongoing independence should be praised and encouraged. As the client gains self-efficacy, the involvement of their case manager should decrease.

The doorway of case management should not be the only entry point to services. Since clients can be engaged in the system in an array of ways, they must be able to access medical care or other services through many different avenues. Regional or agency-based policies and practices should be constructed to help a client continue to receive ongoing support that does not require case management.

Case management systems must have clearly defined outcomes which can be monitored to ensure accountability for the delivery of the service is possible. By viewing case management as a service driven by client need, standard outcomes based on elements of those needs should be developed. The expectations for both providers and clients must be clearly stated and followed. This will strengthen the delivery of service across the state as well as increase the quality and consistency of service delivery by creating accountability measures for the system, the client, the case manager and the case management supervisor.

The goal of case management is to promote and support independence and self-sufficiency. As such, the case management process requires the consent and active participation of the client in decision-making, and supports a client's right to privacy, confidentiality, self-determination, dignity and respect, nondiscrimination, compassionate non-judgmental care, a culturally competent provider, and quality case management services.

The intended outcomes of HIV case management for persons living with HIV include:

- Early access to and maintenance of comprehensive health care and social services.
- Improved integration of services provided across a variety of settings.
- Enhanced continuity of care.
- Prevention of disease transmission and delay of HIV progression.
- Increased knowledge of HIV disease.
- Greater participation in and optimal use of the health and social service system.
- Reinforcement of positive health behaviors.
- Personal empowerment.
- An improved quality of life.

Key activities of HIV case management include:

- Initial assessment of service needs;
- Development of a comprehensive, individualized care plan;
- Coordination of services required to implement the plan;
- Client monitoring to assess the efficacy of the plan; and
- Periodic re-evaluation and adaptation of the plan as necessary over the life of the client.

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- Expands upon our vision of CM
- Language came from Expert Panel report and the DSHS report on the MCM project
- Case management is not the provision of a one-time service nor is it the only entry point into the Ryan White system
- Defines the outcomes and key activities of HIV case management
- Defines MCM vs. Non-MCM

# Overview of Changes
# Service Definitions – page 4

## MCM

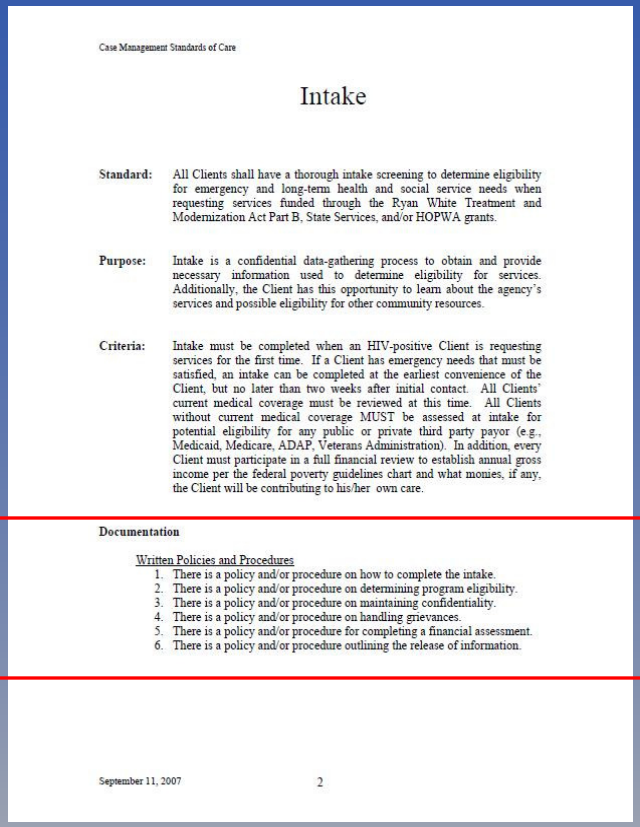
- Multiple complex psychosocial and/or health related needs
- Clients requiring a longer time investment and who agree to an intensive level of CM
- Goals: empower clients with skills to adhere to medical treatment plan without the assistance of MCM; address current needs and help clients in other issues that impact their ability to maintain medical treatment (substance use, mental health, family violence)

## Non-MCM

- Provides assistance in obtaining medical, social, community, legal, financial and other needed services
- Discrete needs that can be addressed in the short-term
- Clients who are transitioning off of MCM but still require a maintenance level of periodic support
- Is NOT coordination or follow-up of medical treatments
- Goals: meet immediate needs of the client at their level of readiness in order to restore or sustain stability; establish a supportive relationship that can lead to MCM services if needed

# Overview of Changes
# P&P Requirements

Prior, the Policies and Procedures requirements were included in each individual section. For this revision, we've pulled all those pieces out into their own document



Case Management Standards of Care

## Intake

**Standard:** All Clients shall have a thorough intake screening to determine eligibility for emergency and long-term health and social service needs when requesting services funded through the Ryan White Treatment and Modernization Act Part B, State Services, and/or HOPWA grants.

**Purpose:** Intake is a confidential data-gathering process to obtain and provide necessary information used to determine eligibility for services. Additionally, the Client has this opportunity to learn about the agency's services and possible eligibility for other community resources.

**Criteria:** Intake must be completed when an HIV-positive Client is requesting services for the first time. If a Client has emergency needs that must be satisfied, an intake can be completed at the earliest convenience of the Client, but no later than two weeks after initial contact. All Clients' current medical coverage must be reviewed at this time. All Clients without current medical coverage MUST be assessed at intake for potential eligibility for any public or private third party payor (e.g., Medicaid, Medicare, ADAP, Veterans Administration). In addition, every Client must participate in a full financial review to establish annual gross income per the federal poverty guidelines chart and what monies, if any, the Client will be contributing to his/her own care.

**Documentation**

Written Policies and Procedures

1. There is a policy and/or procedure on how to complete the intake.
2. There is a policy and/or procedure on determining program eligibility.
3. There is a policy and/or procedure on maintaining confidentiality.
4. There is a policy and/or procedure on handling grievances.
5. There is a policy and/or procedure for completing a financial assessment.
6. There is a policy and/or procedure outlining the release of information.

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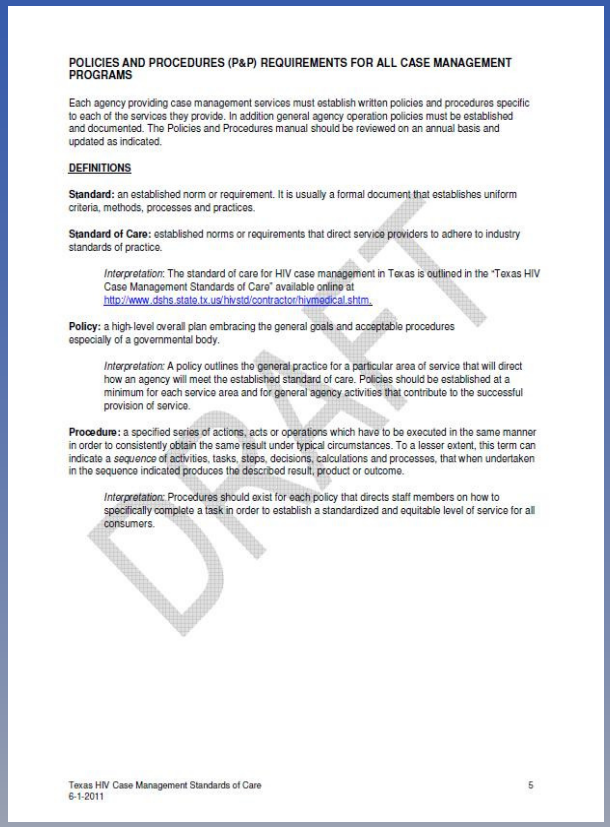

**POLICIES AND PROCEDURES (P&P) REQUIREMENTS FOR ALL CASE MANAGEMENT PROGRAMS**

Each agency providing case management services must establish written policies and procedures specific to each of the services they provide. In addition general agency operation policies must be established and documented. The Policies and Procedures manual should be reviewed on an annual basis and updated as indicated.

**DEFINITIONS**

**Standard:** an established norm or requirement. It is usually a formal document that establishes uniform criteria, methods, processes and practices.

**Standard of Care:** established norms or requirements that direct service providers to adhere to industry standards of practice.

*Interpretation:* The standard of care for HIV case management in Texas is outlined in the "Texas HIV Case Management Standards of Care" available online at http://www.dshs.state.tx.us/hivstd/contractor/hivmedical.shtm.

**Policy:** a high-level overall plan embracing the general goals and acceptable procedures especially of a governmental body.

*Interpretation:* A policy outlines the general practice for a particular area of service that will direct how an agency will meet the established standard of care. Policies should be established at a minimum for each service area and for general agency activities that contribute to the successful provision of service.

**Procedure:** a specified series of actions, acts or operations which have to be executed in the same manner in order to consistently obtain the same result under typical circumstances. To a lesser extent, this term can indicate a *sequence* of activities, tasks, steps, decisions, calculations and processes, that when undertaken in the sequence indicated produces the described result, product or outcome.

*Interpretation:* Procedures should exist for each policy that directs staff members on how to specifically complete a task in order to establish a standardized and equitable level of service for all consumers.

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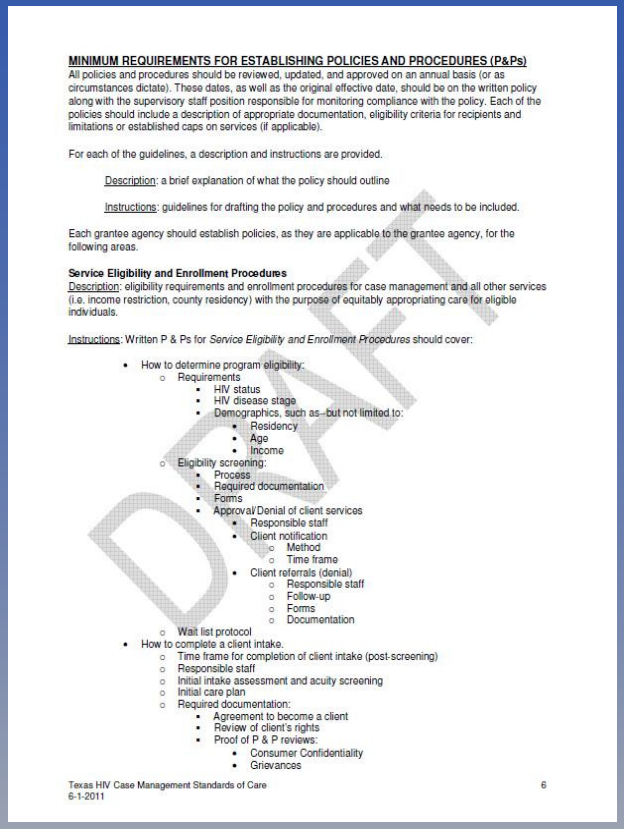
# Overview of Changes
# P&P Requirements - page 5

The P&P document provides guidance on each of the following areas:



**MINIMUM REQUIREMENTS FOR ESTABLISHING POLICIES AND PROCEDURES (P&Ps)**
All policies and procedures should be reviewed, updated, and approved on an annual basis (or as circumstances dictate). These dates, as well as the original effective date, should be on the written policy along with the supervisory staff position responsible for monitoring compliance with the policy. Each of the policies should include a description of appropriate documentation, eligibility criteria for recipients and limitations or established caps on services (if applicable).

For each of the guidelines, a description and instructions are provided.

Description: a brief explanation of what the policy should outline

Instructions: guidelines for drafting the policy and procedures and what needs to be included.

Each grantee agency should establish policies, as they are applicable to the grantee agency, for the following areas.

**Service Eligibility and Enrollment Procedures**
Description: eligibility requirements and enrollment procedures for case management and all other services (i.e. income restriction, county residency) with the purpose of equitably appropriating care for eligible individuals.

Instructions: Written P & Ps for *Service Eligibility and Enrollment Procedures* should cover:

- How to determine program eligibility:
  - Requirements
    - HIV status
    - HIV disease stage
    - Demographics, such as--but not limited to:
      - Residency
      - Age
      - Income
  - Eligibility screening:
    - Process
    - Required documentation
    - Forms
    - Approval/Denial of client services
      - Responsible staff
      - Client notification
        - Method
        - Time frame
      - Client referrals (denial)
        - Responsible staff
        - Follow-up
        - Forms
        - Documentation
  - Wait list protocol
- How to complete a client intake.
  - Time frame for completion of client intake (post-screening)
  - Responsible staff
  - Initial intake assessment and acuity screening
  - Initial care plan
  - Required documentation:
    - Agreement to become a client
    - Review of client's rights
    - Proof of P & P reviews:
      - Consumer Confidentiality
      - Grievances

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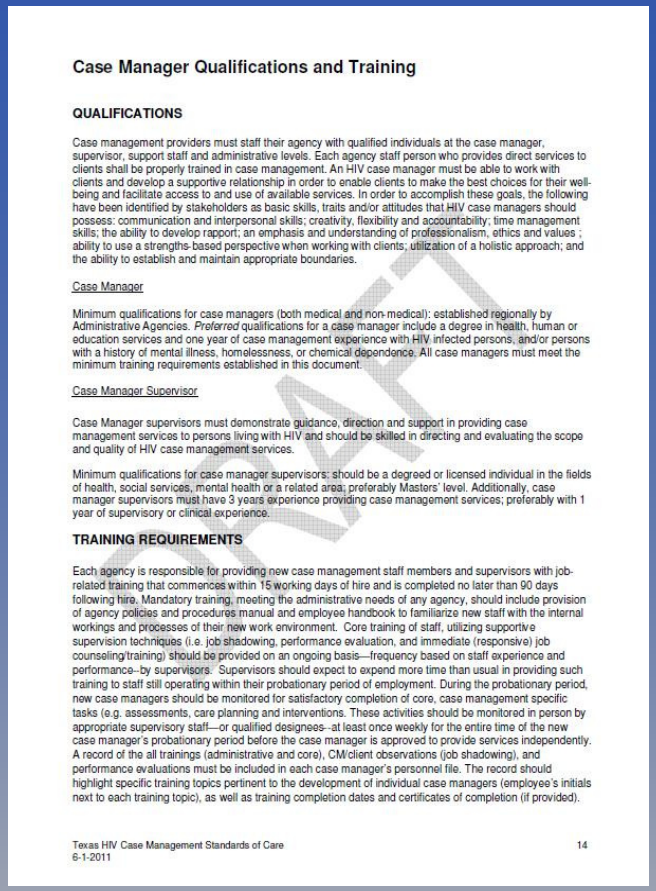
- Service eligibility and Enrollment Procedures
- Crisis Intervention
- Consumer Confidentiality
- Consumer Grievance Procedure
- Data/Reporting
- Quality Management
- Staffing
- Guidance for Policy Development in Specific Service Areas
  - •CM (Assessment, Reassessment and Acuity; Care Plan; Case Conferencing; Caseload Management; Consumer Contacts; Referrals and Follow-up; Case Closure)
  - •Other Support Services (transportation, dental, etc.)

# Overview of Changes
# Case Manager Qualifications and Training - page 14



**Case Manager Qualifications and Training**

**QUALIFICATIONS**

Case management providers must staff their agency with qualified individuals at the case manager, supervisor, support staff and administrative levels. Each agency staff person who provides direct services to clients shall be properly trained in case management. An HIV case manager must be able to work with clients and develop a supportive relationship in order to enable clients to make the best choices for their well-being and facilitate access to and use of available services. In order to accomplish these goals, the following have been identified by stakeholders as basic skills, traits and/or attitudes that HIV case managers should possess: communication and interpersonal skills; creativity, flexibility and accountability; time management skills; the ability to develop rapport; an emphasis and understanding of professionalism, ethics and values ; ability to use a strengths-based perspective when working with clients; utilization of a holistic approach; and the ability to establish and maintain appropriate boundaries.

Case Manager

Minimum qualifications for case managers (both medical and non-medical): established regionally by Administrative Agencies. *Preferred* qualifications for a case manager include a degree in health, human or education services and one year of case management experience with HIV infected persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. All case managers must meet the minimum training requirements established in this document.

Case Manager Supervisor

Case Manager supervisors must demonstrate guidance, direction and support in providing case management services to persons living with HIV and should be skilled in directing and evaluating the scope and quality of HIV case management services.

Minimum qualifications for case manager supervisors: should be a degreed or licensed individual in the fields of health, social services, mental health or a related area; preferably Masters' level. Additionally, case manager supervisors must have 3 years experience providing case management services; preferably with 1 year of supervisory or clinical experience.

**TRAINING REQUIREMENTS**

Each agency is responsible for providing new case management staff members and supervisors with job-related training that commences within 15 working days of hire and is completed no later than 90 days following hire. Mandatory training, meeting the administrative needs of any agency, should include provision of agency policies and procedures manual and employee handbook to familiarize new staff with the internal workings and processes of their new work environment. Core training of staff, utilizing supportive supervision techniques (i.e. job shadowing, performance evaluation, and immediate (responsive) job counseling/training) should be provided on an ongoing basis—frequency based on staff experience and performance--by supervisors. Supervisors should expect to expend more time than usual in providing such training to staff still operating within their probationary period of employment. During the probationary period, new case managers should be monitored for satisfactory completion of core, case management specific tasks (e.g. assessments, care planning and interventions. These activities should be monitored in person by appropriate supervisory staff—or qualified designees--at least once weekly for the entire time of the new case manager's probationary period before the case manager is approved to provide services independently. A record of the all trainings (administrative and core), CM/client observations (job shadowing), and performance evaluations must be included in each case manager's personnel file. The record should highlight specific training topics pertinent to the development of individual case managers (employee's initials next to each training topic), as well as training completion dates and certificates of completion (if provided).

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- Minimum qualifications for CM (MCM and Non-MCM): established regionally by AA
  - •Preferred qualifications include a degree in related field, 1 year CM experience with HIV+, MH/SA, homeless
- Minimum qualifications for CM Supervisors: degreed or licensed in related fields; and 3 years experience providing CM services
  - •Preferred qualifications include 1 year supervisory or clinical experience

# Overview of Changes
# Case Manager Qualifications and Training

Beginning September 1, 2011, all case managers at agencies receiving Ryan White Part B case management funds (both medical and non-medical) must complete the following within 6 months of hire (it's recommended that staff complete training within 3 months of hire):

**Initial Courses REQUIRED for all Case Managers:**

1. **Unified Health Communication 101: Addressing Health Literacy, Cultural Competency and Limited English Proficiency (on-line)***
2. **Texas HIV Medication Program (on-line)***
3. **HIV Case Management 101: A Foundation (on-line)***
4. **HIV Case Management 101: A Foundation Part Two (in-person follow-up)**

**These courses are all available through the TRAIN Texas learning management system.*

**The above courses address the following core competencies:**

Case Management role and processes
Funding
Harm Reduction
Client-Centered approach
Medical Literacy/HIV knowledge
Mental Health
Patient Education
Substance Abuse

Exceptions to this rule *may* be waived by Texas DSHS HIV Program training staff. For current training requirements, contact the HIV Case Management Training Specialist with the Texas DSHS HIV Program.

# Overview of Changes
# Case Manager Qualifications and Training

**REQUIRED Medical Case Manager Training**

Beginning **January 1, 2012,** staff performing medical case management at agencies receiving Ryan White Part B case management funds must fulfill the **Texas DSHS HIV Program Medical Case Manager Competency Training Course** requirements. New Medical Case Managers must complete all components of the MCM Competency Training Course within 12 months of hire (it's recommended that staff complete training within 9 months of hire). This course addresses the following core competencies:

Medical Literacy and HIV knowledge
Harm Reduction
Mental Health / Substance Use
Confidentiality/Legal/Consent
Behavioral Intelligence and skills
Cultural Competency
Intake/Assessment/Reassessment
Patient Education
Family Violence

# Overview of Changes
# Case Manager Qualifications and Training

**Ongoing Courses REQUIRED for all Case Managers**

In addition, all case managers (medical and non-medical) must complete a minimum of 12 hours of continuing education annually. Training should be aimed at the following core competencies:

**Core Proficiencies:**

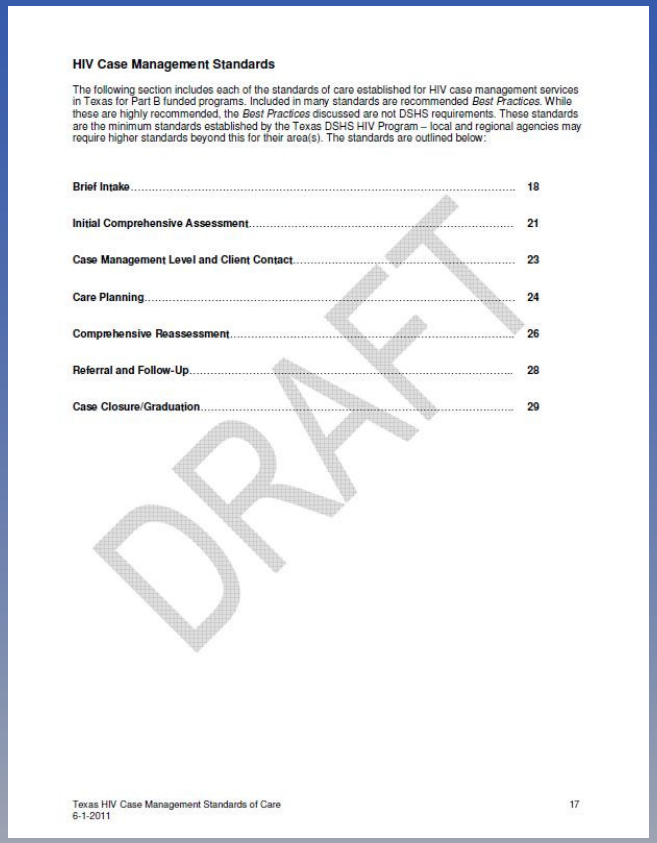
| | |
|---|---|
| HIV Confidentiality and the Law | Ethics and HIV |
| Cultural Competency | Hepatitis A, B, C |
| Working with Special Populations (undocumented, LGBT, Women, African-American, Latino, over 50, etc.) | Screening Tools (substance use, mental health, risk behavior) |
| Family Violence | HIV Disclosure |
| Intake/Assessment/Reassessment | Harm Reduction |
| Monitoring/Outcomes | Mental Health/Substance Use |
| Records Management | Substance Use |
| Resource Development/Use | HIV Medication |
| Safety | Opportunistic Infections |
| Care Planning and Implementation | STDs |

Please contact the HIV Case Management Training Specialist for available training opportunities. Other topics not listed above may be used to fulfill the requirement; however, courses must be approved by DSHS and should be submitted prior to attending training. Participants should submit a copy of the training agenda to the HIV Case Management Training Specialist for consideration.

Individual agencies and/or case management supervisors are responsible for monitoring case manager compliance with on-going training requirements and certification maintenance, including authorizing appropriate training opportunities to satisfy the maintenance requirements. Personnel records related to training and certification are subject to review during routine audits.

# Overview of Changes
# HIV Case Management Standards - page 17

We've changed the format of the standards to make the information clearer and easier to follow. Most of the language has been transferred from the 'old' standards. Additionally, we've included recommended best practices for many standards to provide additional guidance to case management programs



**HIV Case Management Standards**

The following section includes each of the standards of care established for HIV case management services in Texas for Part B funded programs. Included in many standards are recommended *Best Practices*. While these are highly recommended, the *Best Practices* discussed are not DSHS requirements. These standards are the minimum standards established by the Texas DSHS HIV Program – local and regional agencies may require higher standards beyond this for their area(s). The standards are outlined below:

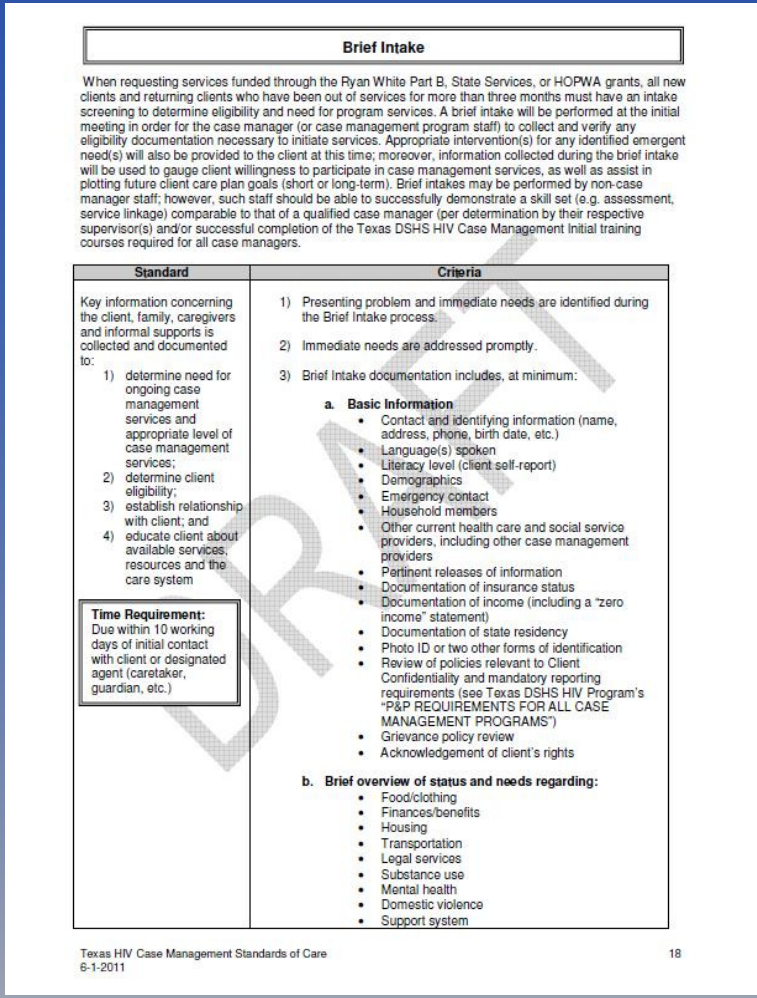






- Brief Intake
- Initial Comprehensive Assessment
- Case Management Level and Client Contact
- Care Planning
- Comprehensive Reassessment
- Referral and Follow-Up
- Case Closure/Graduation

# Overview of Changes
# HIV Case Management Standards: Brief Intake



**Brief Intake**

When requesting services funded through the Ryan White Part B, State Services, or HOPWA grants, all new clients and returning clients who have been out of services for more than three months must have an intake screening to determine eligibility and need for program services. A brief intake will be performed at the initial meeting in order for the case manager (or case management program staff) to collect and verify any eligibility documentation necessary to initiate services. Appropriate intervention(s) for any identified emergent need(s) will also be provided to the client at this time; moreover, information collected during the brief intake will be used to gauge client willingness to participate in case management services, as well as assist in plotting future client care plan goals (short or long-term). Brief intakes may be performed by non-case manager staff; however, such staff should be able to successfully demonstrate a skill set (e.g. assessment, service linkage) comparable to that of a qualified case manager (per determination by their respective supervisor(s) and/or successful completion of the Texas DSHS HIV Case Management Initial training courses required for all case managers.

| Standard | Criteria |
|---|---|
| Key information concerning the client, family, caregivers and informal supports is collected and documented to:<br>1) determine need for ongoing case management services and appropriate level of case management services;<br>2) determine client eligibility;<br>3) establish relationship with client; and<br>4) educate client about available services, resources and the care system<br><br>**Time Requirement:** Due within 10 working days of initial contact with client or designated agent (caretaker, guardian, etc.) | 1) Presenting problem and immediate needs are identified during the Brief Intake process.<br>2) Immediate needs are addressed promptly.<br>3) Brief Intake documentation includes, at minimum:<br>**a. Basic Information**<br>• Contact and identifying information (name, address, phone, birth date, etc.)<br>• Language(s) spoken<br>• Literacy level (client self-report)<br>• Demographics<br>• Emergency contact<br>• Household members<br>• Other current health care and social service providers, including other case management providers<br>• Pertinent releases of information<br>• Documentation of insurance status<br>• Documentation of income (including a "zero income" statement)<br>• Documentation of state residency<br>• Photo ID or two other forms of identification<br>• Review of policies relevant to Client Confidentiality and mandatory reporting requirements (see Texas DSHS HIV Program's "P&P REQUIREMENTS FOR ALL CASE MANAGEMENT PROGRAMS")<br>• Grievance policy review<br>• Acknowledgement of client's rights<br>**b. Brief overview of status and needs regarding:**<br>• Food/clothing<br>• Finances/benefits<br>• Housing<br>• Transportation<br>• Legal services<br>• Substance use<br>• Mental health<br>• Domestic violence<br>• Support system |

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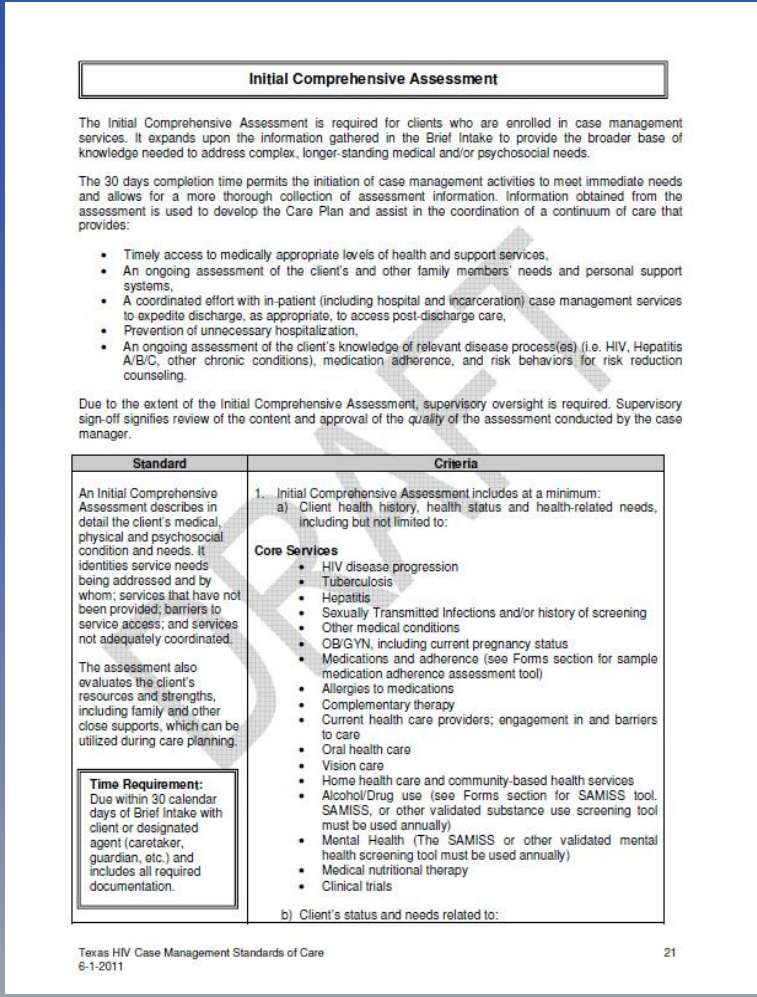
- Primary goal of the Brief Intake is to collect and verify eligibility documentation necessary to initiate services
- Additional goals of the Brief Intake include: identify and address immediate (crisis) needs; determine need for ongoing CM and appropriate level of CM; establish relationship with client and educate client about available services
- Can be performed by non-case management staff (who have received appropriate training)
- Intention is to decrease the amount of time it takes to complete an intake

# Overview of Changes
# HIV Case Management Standards: Initial Comprehensive Assessment



**Initial Comprehensive Assessment**

The Initial Comprehensive Assessment is required for clients who are enrolled in case management services. It expands upon the information gathered in the Brief Intake to provide the broader base of knowledge needed to address complex, longer-standing medical and/or psychosocial needs.

The 30 days completion time permits the initiation of case management activities to meet immediate needs and allows for a more thorough collection of assessment information. Information obtained from the assessment is used to develop the Care Plan and assist in the coordination of a continuum of care that provides:

- Timely access to medically appropriate levels of health and support services,
- An ongoing assessment of the client's and other family members' needs and personal support systems,
- A coordinated effort with in-patient (including hospital and incarceration) case management services to expedite discharge, as appropriate, to access post-discharge care,
- Prevention of unnecessary hospitalization,
- An ongoing assessment of the client's knowledge of relevant disease process(es) (i.e. HIV, Hepatitis A/B/C, other chronic conditions), medication adherence, and risk behaviors for risk reduction counseling.

Due to the extent of the Initial Comprehensive Assessment, supervisory oversight is required. Supervisory sign-off signifies review of the content and approval of the *quality* of the assessment conducted by the case manager.

| Standard | Criteria |
|---|---|
| An Initial Comprehensive Assessment describes in detail the client's medical, physical and psychosocial condition and needs. It identities service needs being addressed and by whom; services that have not been provided; barriers to service access; and services not adequately coordinated.<br><br>The assessment also evaluates the client's resources and strengths, including family and other close supports, which can be utilized during care planning.<br><br>**Time Requirement:** Due within 30 calendar days of Brief Intake with client or designated agent (caretaker, guardian, etc.) and includes all required documentation. | 1. Initial Comprehensive Assessment includes at a minimum:<br>a) Client health history, health status and health-related needs, including but not limited to:<br><br>**Core Services**<br>• HIV disease progression<br>• Tuberculosis<br>• Hepatitis<br>• Sexually Transmitted Infections and/or history of screening<br>• Other medical conditions<br>• OB/GYN, including current pregnancy status<br>• Medications and adherence (see Forms section for sample medication adherence assessment tool)<br>• Allergies to medications<br>• Complementary therapy<br>• Current health care providers; engagement in and barriers to care<br>• Oral health care<br>• Vision care<br>• Home health care and community-based health services<br>• Alcohol/Drug use (see Forms section for SAMISS tool. SAMISS, or other validated substance use screening tool must be used annually)<br>• Mental Health (The SAMISS or other validated mental health screening tool must be used annually)<br>• Medical nutritional therapy<br>• Clinical trials<br><br>b) Client's status and needs related to: |





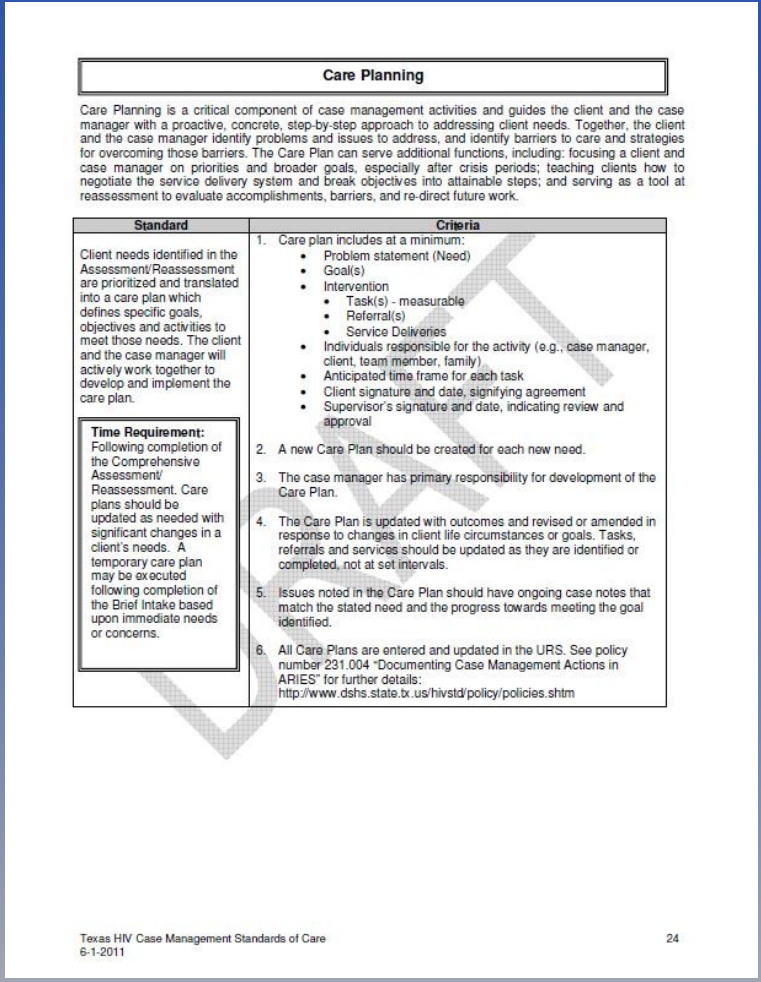
- Required for all clients enrolled in CM services. Expands upon information collected during the Brief Intake.
- Must be completed and documented within 30 days of Brief Intake. This time frame is to permit the initiation of CM activities to meet basic needs and to allow for a more thorough collection of assessment information.
- Supervisory oversight is required (as before) with an emphasis on approving the quality of the assessment conducted
- Includes process for discharging a client who hasn't given necessary requested information
- Information collected here is the same as the 'old' standard except information about acuity and client contact has been pulled out into its own standard

# Overview of Changes
# HIV Case Management Standards: Case Management Level and Client Contact

- Case Management Level must be determined using an acuity scale to determine the client's level of need for services and how those needs impact the CM system
- Emphasizes that acuity scales are *TOOLS* for case managers to use; not a replacement for case manager judgment
- CM and client use information from the Brief Intake and Comprehensive Assessment to determine an acuity score. Acuity scores and the case manager's professional judgment should be used to determine level (intensity) of case management
- There should be a clear correlation between acuity score, case management level and frequency of contact

- No specific acuity tool is required. DSHS recommends the use of successfully tested acuity scales which cover the following areas: medical/clinical, life skills, mental health, substance use, housing, support system, insurance benefits, transportation, legal, cultural/linguistic, self efficacy in daily functioning, HIV education and risk reduction, employment/income, medication adherence
- DSHS recommends the System Acuity Measurement (SAM) as it has been successfully tested with an HIV+ population
- Acuity scores DO NOT replace case manager judgment. Case Management levels which do not trend with the acuity score are allowed as long as the case manager appropriately documents why they are making this decision

# Overview of Changes
# HIV Case Management Standards: Care Planning



**Care Planning**

Care Planning is a critical component of case management activities and guides the client and the case manager with a proactive, concrete, step-by-step approach to addressing client needs. Together, the client and the case manager identify problems and issues to address, and identify barriers to care and strategies for overcoming those barriers. The Care Plan can serve additional functions, including: focusing a client and case manager on priorities and broader goals, especially after crisis periods; teaching clients how to negotiate the service delivery system and break objectives into attainable steps; and serving as a tool at reassessment to evaluate accomplishments, barriers, and re-direct future work.

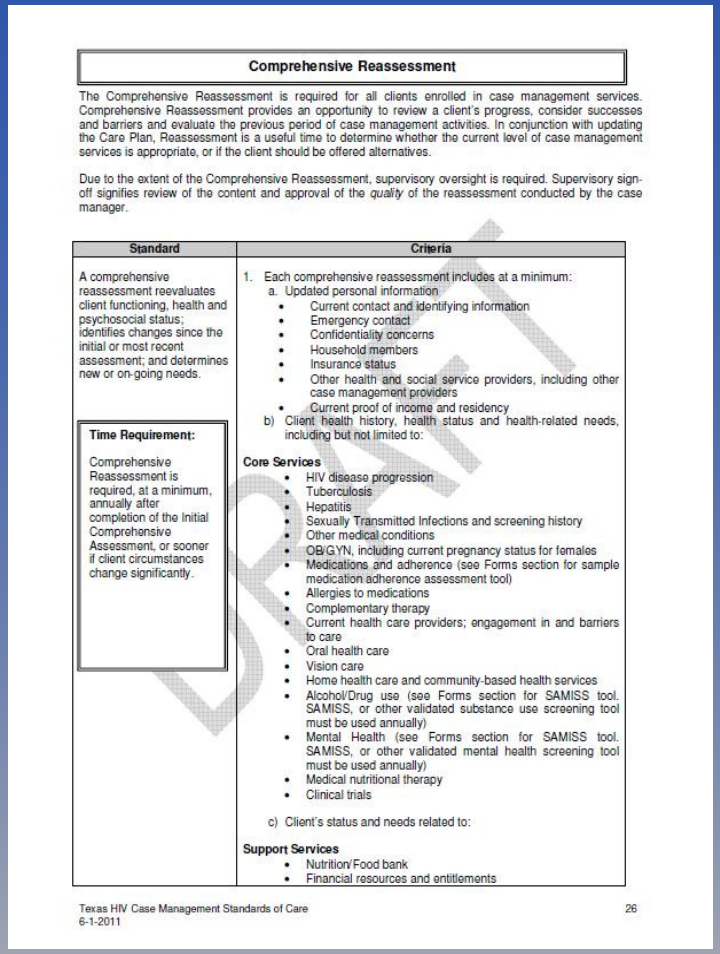
| Standard | Criteria |
|---|---|
| Client needs identified in the Assessment/Reassessment are prioritized and translated into a care plan which defines specific goals, objectives and activities to meet those needs. The client and the case manager will actively work together to develop and implement the care plan.<br><br>**Time Requirement:** Following completion of the Comprehensive Assessment/ Reassessment. Care plans should be updated as needed with significant changes in a client's needs. A temporary care plan may be executed following completion of the Brief Intake based upon immediate needs or concerns. | 1. Care plan includes at a minimum:<br>• Problem statement (Need)<br>• Goal(s)<br>• Intervention<br>  • Task(s) - measurable<br>  • Referral(s)<br>  • Service Deliveries<br>• Individuals responsible for the activity (e.g., case manager, client, team member, family)<br>• Anticipated time frame for each task<br>• Client signature and date, signifying agreement<br>• Supervisor's signature and date, indicating review and approval<br>2. A new Care Plan should be created for each new need.<br>3. The case manager has primary responsibility for development of the Care Plan.<br>4. The Care Plan is updated with outcomes and revised or amended in response to changes in client life circumstances or goals. Tasks, referrals and services should be updated as they are identified or completed, not at set intervals.<br>5. Issues noted in the Care Plan should have ongoing case notes that match the stated need and the progress towards meeting the goal identified.<br>6. All Care Plans are entered and updated in the URS. See policy number 231.004 "Documenting Case Management Actions in ARIES" for further details: http://www.dshs.state.tx.us/hivstd/policy/policies.shtm |





- Time frame changed – Care Plan must be completed upon the completion of the Comprehensive Assessment/ Reassessment and updated as needed with changes in a client's life (used to say within 7 days of intake)
- Includes minimum details required in a Care Plan (based on policy "Documenting CM Actions in ARIES")
- Requires there be case notes related to issues identified in the Care Plan and the progress towards meeting the goals identified
- Best Practices component borrowed from BVCOG training on Care Planning

# Overview of Changes
# HIV Case Management Standards: Comprehensive Reassessment



**Comprehensive Reassessment**

The Comprehensive Reassessment is required for all clients enrolled in case management services. Comprehensive Reassessment provides an opportunity to review a client's progress, consider successes and barriers and evaluate the previous period of case management activities. In conjunction with updating the Care Plan, Reassessment is a useful time to determine whether the current level of case management services is appropriate, or if the client should be offered alternatives.

Due to the extent of the Comprehensive Reassessment, supervisory oversight is required. Supervisory sign-off signifies review of the content and approval of the *quality* of the reassessment conducted by the case manager.

| Standard | Criteria |
|---|---|
| A comprehensive reassessment reevaluates client functioning, health and psychosocial status; identifies changes since the initial or most recent assessment; and determines new or on-going needs.<br><br>**Time Requirement:**<br>Comprehensive Reassessment is required, at a minimum, annually after completion of the Initial Comprehensive Assessment, or sooner if client circumstances change significantly. | 1. Each comprehensive reassessment includes at a minimum:<br>a. Updated personal information<br>• Current contact and identifying information<br>• Emergency contact<br>• Confidentiality concerns<br>• Household members<br>• Insurance status<br>• Other health and social service providers, including other case management providers<br>• Current proof of income and residency<br>b) Client health history, health status and health-related needs, including but not limited to:<br>**Core Services**<br>• HIV disease progression<br>• Tuberculosis<br>• Hepatitis<br>• Sexually Transmitted Infections and screening history<br>• Other medical conditions<br>• OB/GYN, including current pregnancy status for females<br>• Medications and adherence (see Forms section for sample medication adherence assessment tool)<br>• Allergies to medications<br>• Complementary therapy<br>• Current health care providers; engagement in and barriers to care<br>• Oral health care<br>• Vision care<br>• Home health care and community-based health services<br>• Alcohol/Drug use (see Forms section for SAMISS tool. SAMISS, or other validated substance use screening tool must be used annually)<br>• Mental Health (see Forms section for SAMISS tool. SAMISS, or other validated mental health screening tool must be used annually)<br>• Medical nutritional therapy<br>• Clinical trials<br>c) Client's status and needs related to:<br>**Support Services**<br>• Nutrition/Food bank<br>• Financial resources and entitlements |

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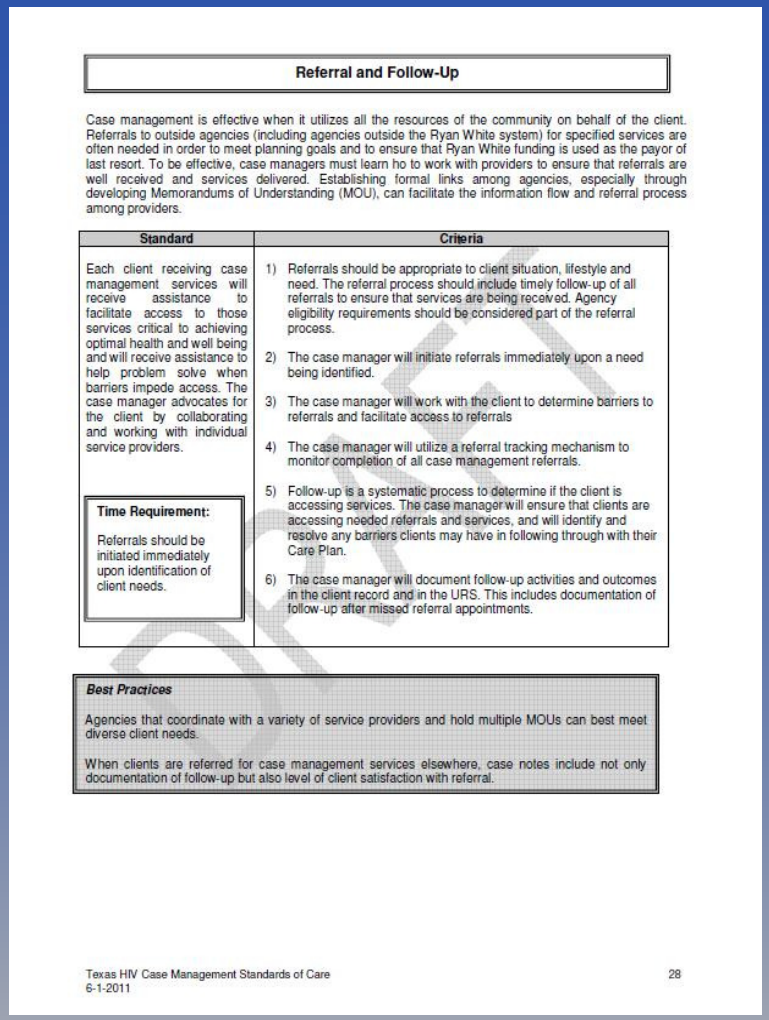
- Same information required in the Comprehensive Assessment
- Required, at minimum, annually

# Overview of Changes
# HIV Case Management Standards: Referral and Follow-Up



**Referral and Follow-Up**

Case management is effective when it utilizes all the resources of the community on behalf of the client. Referrals to outside agencies (including agencies outside the Ryan White system) for specified services are often needed in order to meet planning goals and to ensure that Ryan White funding is used as the payor of last resort. To be effective, case managers must learn ho to work with providers to ensure that referrals are well received and services delivered. Establishing formal links among agencies, especially through developing Memorandums of Understanding (MOU), can facilitate the information flow and referral process among providers.

| Standard | Criteria |
|---|---|
| Each client receiving case management services will receive assistance to facilitate access to those services critical to achieving optimal health and well being and will receive assistance to help problem solve when barriers impede access. The case manager advocates for the client by collaborating and working with individual service providers. | 1) Referrals should be appropriate to client situation, lifestyle and need. The referral process should include timely follow-up of all referrals to ensure that services are being received. Agency eligibility requirements should be considered part of the referral process.<br>2) The case manager will initiate referrals immediately upon a need being identified.<br>3) The case manager will work with the client to determine barriers to referrals and facilitate access to referrals<br>4) The case manager will utilize a referral tracking mechanism to monitor completion of all case management referrals.<br>5) Follow-up is a systematic process to determine if the client is accessing services. The case manager will ensure that clients are accessing needed referrals and services, and will identify and resolve any barriers clients may have in following through with their Care Plan.<br>6) The case manager will document follow-up activities and outcomes in the client record and in the URS. This includes documentation of follow-up after missed referral appointments. |
| **Time Requirement:**<br>Referrals should be initiated immediately upon identification of client needs. | |

***Best Practices***

Agencies that coordinate with a variety of service providers and hold multiple MOUs can best meet diverse client needs.

When clients are referred for case management services elsewhere, case notes include not only documentation of follow-up but also level of client satisfaction with referral.

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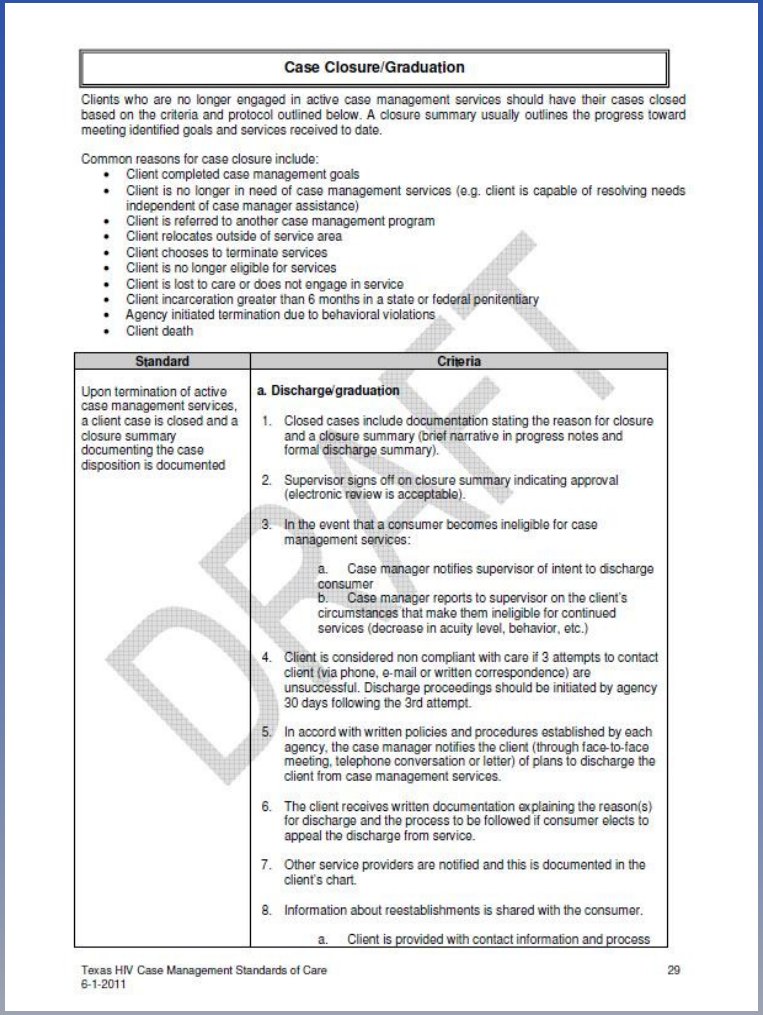
- Removed the 2 week timeframe in the ‘old’ standards – referrals should be initiated immediately upon identification of client needs
- Language emphasizes ‘payor of last resort’ policy by utilizing and documenting referrals as a way to meet the requirements of this policy
- Encourages the use of MOUs to facilitate the information flow and referral process

# Overview of Changes
# HIV Case Management Standards: Case Closure/Graduation



**Case Closure/Graduation**

Clients who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined below. A closure summary usually outlines the progress toward meeting identified goals and services received to date.

Common reasons for case closure include:

- Client completed case management goals
- Client is no longer in need of case management services (e.g. client is capable of resolving needs independent of case manager assistance)
- Client is referred to another case management program
- Client relocates outside of service area
- Client chooses to terminate services
- Client is no longer eligible for services
- Client is lost to care or does not engage in service
- Client incarceration greater than 6 months in a state or federal penitentiary
- Agency initiated termination due to behavioral violations
- Client death

| Standard | Criteria |
|---|---|
| Upon termination of active case management services, a client case is closed and a closure summary documenting the case disposition is documented | **a. Discharge/graduation**<br>1. Closed cases include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal discharge summary).<br>2. Supervisor signs off on closure summary indicating approval (electronic review is acceptable).<br>3. In the event that a consumer becomes ineligible for case management services:<br>a. Case manager notifies supervisor of intent to discharge consumer<br>b. Case manager reports to supervisor on the client's circumstances that make them ineligible for continued services (decrease in acuity level, behavior, etc.)<br>4. Client is considered non compliant with care if 3 attempts to contact client (via phone, e-mail or written correspondence) are unsuccessful. Discharge proceedings should be initiated by agency 30 days following the 3rd attempt.<br>5. In accord with written policies and procedures established by each agency, the case manager notifies the client (through face-to-face meeting, telephone conversation or letter) of plans to discharge the client from case management services.<br>6. The client receives written documentation explaining the reason(s) for discharge and the process to be followed if consumer elects to appeal the discharge from service.<br>7. Other service providers are notified and this is documented in the client's chart.<br>8. Information about reestablishments is shared with the consumer.<br>a. Client is provided with contact information and process |

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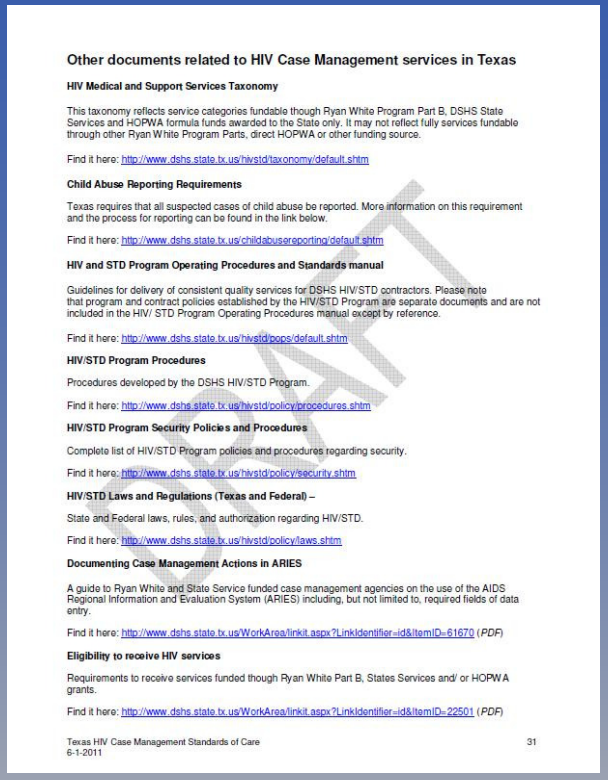
- Changed the language from "Discharge/Transfer" to "Case Closure/Graduation" to more accurately reflect the activity
- Language added to integrate "Documenting CM Actions in ARIES" – e.g. "completing goals/no longer has need for CM services" is now a reason for case closure/graduation
- Clarifies documentation process for closing a client's case and requires that CM share information with clients about re-establishing services

# Overview of Changes
# Additional Documents

Additionally, we've added a section with a listing of other relevant documents, common acronyms and sample forms/screening tools. We plan to continue building these pieces as necessary and as additional resources are identified



## Other documents related to HIV Case Management services in Texas

**HIV Medical and Support Services Taxonomy**

This taxonomy reflects service categories fundable though Ryan White Program Part B, DSHS State Services and HOPWA formula funds awarded to the State only. It may not reflect fully services fundable through other Ryan White Program Parts, direct HOPWA or other funding source.

Find it here: http://www.dshs.state.tx.us/hivstd/taxonomy/default.shtm

**Child Abuse Reporting Requirements**

Texas requires that all suspected cases of child abuse be reported. More information on this requirement and the process for reporting can be found in the link below.

Find it here: http://www.dshs.state.tx.us/childabusereporting/default.shtm

**HIV and STD Program Operating Procedures and Standards manual**

Guidelines for delivery of consistent quality services for DSHS HIV/STD contractors. Please note that program and contract policies established by the HIV/STD Program are separate documents and are not included in the HIV/ STD Program Operating Procedures manual except by reference.

Find it here: http://www.dshs.state.tx.us/hivstd/pops/default.shtm

**HIV/STD Program Procedures**

Procedures developed by the DSHS HIV/STD Program.

Find it here: http://www.dshs.state.tx.us/hivstd/policy/procedures.shtm

**HIV/STD Program Security Policies and Procedures**

Complete list of HIV/STD Program policies and procedures regarding security.

Find it here: http://www.dshs.state.tx.us/hivstd/policy/security.shtm

**HIV/STD Laws and Regulations (Texas and Federal) –**

State and Federal laws, rules, and authorization regarding HIV/STD.

Find it here: http://www.dshs.state.tx.us/hivstd/policy/laws.shtm

**Documenting Case Management Actions in ARIES**

A guide to Ryan White and State Service funded case management agencies on the use of the AIDS Regional Information and Evaluation System (ARIES) including, but not limited to, required fields of data entry.

Find it here: http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=61670 (*PDF*)

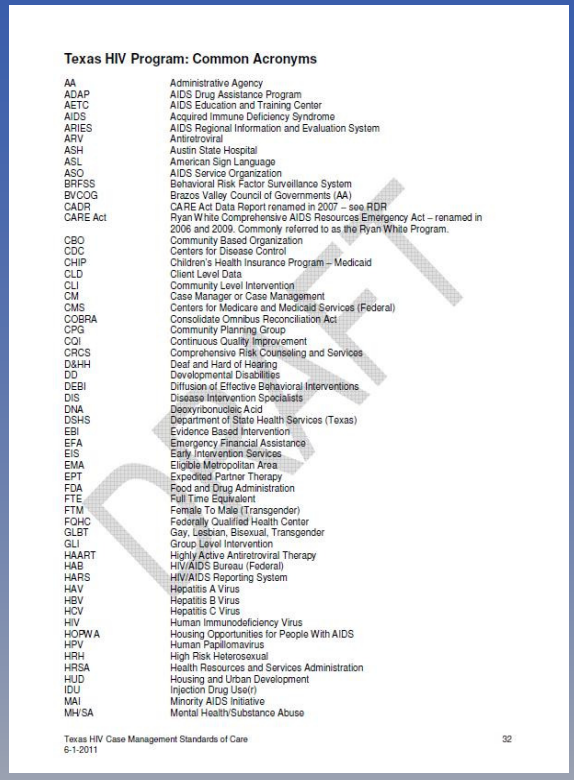
**Eligibility to receive HIV services**

Requirements to receive services funded though Ryan White Part B, States Services and/ or HOPWA grants.

Find it here: http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=22501 (*PDF*)





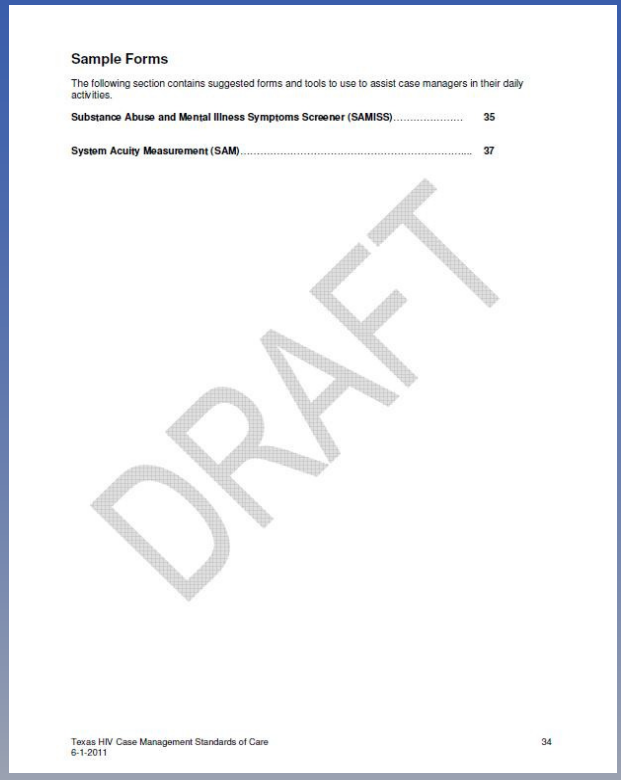


## Texas HIV Program: Common Acronyms

| | |
|---|---|
| AA | Administrative Agency |
| ADAP | AIDS Drug Assistance Program |
| AETC | AIDS Education and Training Center |
| AIDS | Acquired Immune Deficiency Syndrome |
| ARIES | AIDS Regional Information and Evaluation System |
| ARV | Antiretroviral |
| ASH | Austin State Hospital |
| ASL | American Sign Language |
| ASO | AIDS Service Organization |
| BRFSS | Behavioral Risk Factor Surveillance System |
| BVCOG | Brazos Valley Council of Governments (AA) |
| CADR | CARE Act Data Report renamed in 2007 – see RDR |
| CARE Act | Ryan White Comprehensive AIDS Resources Emergency Act – renamed in 2006 and 2009. Commonly referred to as the Ryan White Program. |
| CBO | Community Based Organization |
| CDC | Centers for Disease Control |
| CHIP | Children's Health Insurance Program – Medicaid |
| CLD | Client Level Data |
| CLI | Community Level Intervention |
| CM | Case Manager or Case Management |
| CMS | Centers for Medicare and Medicaid Services (Federal) |
| COBRA | Consolidate Omnibus Reconciliation Act |
| CPG | Community Planning Group |
| CQI | Continuous Quality Improvement |
| CRCS | Comprehensive Risk Counseling and Services |
| D&HH | Deaf and Hard of Hearing |
| DD | Developmental Disabilities |
| DEBI | Diffusion of Effective Behavioral Interventions |
| DIS | Disease Intervention Specialists |
| DNA | Deoxyribonucleic Acid |
| DSHS | Department of State Health Services (Texas) |
| EBI | Evidence Based Intervention |
| EFA | Emergency Financial Assistance |
| EIS | Early Intervention Services |
| EMA | Eligible Metropolitan Area |
| EPT | Expedited Partner Therapy |
| FDA | Food and Drug Administration |
| FTE | Full Time Equivalent |
| FTM | Female To Male (Transgender) |
| FQHC | Federally Qualified Health Center |
| GLBT | Gay, Lesbian, Bisexual, Transgender |
| GLI | Group Level Intervention |
| HAART | Highly Active Antiretroviral Therapy |
| HAB | HIV/AIDS Bureau (Federal) |
| HARS | HIV/AIDS Reporting System |
| HAV | Hepatitis A Virus |
| HBV | Hepatitis B Virus |
| HCV | Hepatitis C Virus |
| HIV | Human Immunodeficiency Virus |
| HOPWA | Housing Opportunities for People With AIDS |
| HPV | Human Papillomavirus |
| HRH | High Risk Heterosexual |
| HRSA | Health Resources and Services Administration |
| HUD | Housing and Urban Development |
| IDU | Injection Drug Use(r) |
| MAI | Minority AIDS Initiative |
| MH/SA | Mental Health/Substance Abuse |







## Sample Forms

The following section contains suggested forms and tools to use to assist case managers in their daily activities.

For more information and to provide feedback, please e-mail Ann Dills:

ann.dills@dshs.state.tx.us